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POC #1	445262	A. BUILDING _____ B. WING _____	05/21/2019

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CUMBERLAND HEALTH CARE AND REHABILITATION INC	4343 ASHLAND CITY HWY NASHVILLE, TN 37218

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F 000	INITIAL COMMENTS A recertification survey was completed on 5/19/19 to 5/21/19 at Cumberland Health Care and Rehabilitation Inc. Deficiencies were cited related to the recertification survey under 42 CFR PART 483, Requirements for Long Term Care Facilities.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws.	F 583	F583 SS=D 483.10(h)(1)-(3)(i)(ii) Personal Privacy/Confidentiality of Records Resident #21 1. On 5/21/19, upon being notified of the deficient practice, the Regional Nurse Consultant confirmed that the computer screen was no longer visible and the resident information was not displayed in view of other residents. On 5/21/19 the Regional Nurse Consultant secured the medications associated with the cart. Nurse #1 was relieved of her responsibility of the medication cart on 5/21/19 and received disciplinary action from the administrator. The Director of Nursing conducted a review of the facility policy regarding the privacy of resident medical records on 5/21/19, with no changes recommended.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Savannah Choate	Administrator	06/07/19

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F 583	Continued From page 1 (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on facility policy review, observation and interview, the facility failed to secure the personal privacy and confidentiality of medical records for 1 resident (#21) of 45 residents reviewed. The findings include: Facility policy review, Resident Rights dated 11/2016 with revision on 11/2017, revealed "...The resident has a right to personal privacy and confidentiality of his or her personal and medical records..." Medical record review revealed Resident #21 was admitted to the facility on 9/9/18 with diagnoses which included Acute Embolism and Thrombosis of Left Femoral Vein, Generalized Edema, and Cerebrovascular Disease. Observation on 5/21/19 at 8:18 AM on the 200 Hall in the presence of the support staff administrator revealed the 200 Hall medication cart was left unattended with the computer screen visible with Resident #21's photo and medical information displayed. Continued observation revealed two residents were sitting in the hallway near the medication cart and visitors and staff walked by the medication cart. Interview with the support staff administrator on 5/21/19 at 8:21 AM in the 200 Hall confirmed the 200 Hall medication was cart unattended and	F 583	2. The facility has determined that all residents have the potential to be affected. The Administrator and Director of Nursing reviewed the Resident Rights policy for revisions, no revisions were indicated at this time. Licensed nurses were in-serviced by the Director of Nursing on 06/07/2019 regarding the requirements to maintain confidentiality of residents and resident information from visitors and/or other residents. Additional in-servicing has been scheduled by the Director of Nursing for 6/20/19 for the licensed Nurses regarding maintaining privacy of medical records during medication pass/administration. 3. To ensure this practice does not reoccur the Director of Nursing or designee will audit the medication pass bi-weekly for the next 4 weeks, then weekly for twelve weeks. Findings will be recorded by the Director of Nursing or designee on a privacy/med pass audit form. The Director of Nursing will report the findings to the Quality Assurance Performance Improvement (QAPI) committee. Newly hired licensed nurses will be instructed on patient rights and privacy during orientation and annual competency testing by the Director of Nursing or designee.	

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F 583	Continued From page 2 Resident #21's information was in view of anyone who was near or passed by the medication cart. Continued interview confirmed the nurses were to be in attendance of the medication carts at all times and resident information was not to be displayed and left in view of visitors or other residents.	F 583	4. In order to ensure ongoing compliance the privacy/med pass audit form will be reviewed by the Administrator weekly for the next twelve weeks. The administrator will report monitoring results and audit findings to the QAPI committee for tracking and trending. Adverse findings will be addressed by the QAPI committee.	5/29/19
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review, and interview, the facility failed to coordinate the timely completion of a Level II Pre-Admission Screening and Resident Review (PASRR) for 1 Resident (#24) of 45 residents reviewed.	F 644	**F644 SS-D 483.20 (e)(1)(2) Coordination of PASARR and Assessments** **Resident #24** Upon being notified of the deficient practice, the ADON reviewed Resident #24 medical records and conducted a Level II PASRR. All residents could potentially be affected. An audit will be conducted by the DON/designee on all resident medical records for newly evident or possible serious mental disorder, intellectual disability or related conditions requiring a mental status change which would prompt a Level II PASRR by 06/30/2019. The DON or designated representative will audit the Facility PASARR program for the next 3 months and report findings to the Administrator. Any adverse findings of the audits will be addressed and the appropriate PASSAR will be completed as necessary. A new PASSAR will be resubmitted as indicated. The Assistant Director of Nursing was inserviced by the Administrator on the requirements of the Level I and II PASSAR system on 6/7/19.	

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F 644	Continued From page 3 The findings include: Facility policy review, PASRR- Pre-Admission Screening and Resident Review dated 3/2019, revealed "...Any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or a related condition will require a Mental Status Change (a new Level 1 PASRR), which will prompt a Level II review by the state mental health or intellectual disability authority..." Medical record review revealed Resident #24 was admitted to the facility on 7/28/14 with diagnoses which included Type 2 Diabetes Mellitus, Hypertension, and Dysphagia. Medical record review revealed Resident #24 had a PASRR Level I completed on 7/28/14. Further record review revealed Resident #24 did not have a Level II PASRR. Medical record review of the Quarterly Minimum Data Set (MDS) dated 1/1/19 revealed Resident #24's active diagnoses included Depression. Medical record review of the Quarterly MDS dated 3/21/19 revealed Resident #24's active diagnoses included Depression, Anxiety Disorder and Psychotic Disorder. Interview with RN #1 on 5/20/19 at 2:30 PM in the conference room confirmed a Level II PASRR had not been completed for Resident #24.	F 644	In order to ensure ongoing compliance, the PASRR audit form will be reviewed by the Administrator weekly for the next three months for tracking and trending the corrective action. The Administrator will report the monitoring results at the monthly QAPI meeting for the next three months. The administrator will report the monitoring results to the Govrning Body at their next meeting.	6/30/19
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care	F 655	F655 SS=D 483.21(a)(1)-(3) Baseline Care Plan Resident #59 and #67	

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F 655	Continued From page 4 Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting	F 655	On 5/21/19, the Administrator and Director of Nursing reviewed why a Baseline Care Plan was not developed for Resident # 59 and #67. It was determined that a baseline care plan was initiated but not within the designated time frame. On 6/7/19, an in-service was conducted by DON or designee with nursing staff (RNs, LPNs), on timely completion of a Baseline Care Plans. All newly admitted residents have a potential to be affected by the deficient practice. On 5/21/19 the DON/designee reviewed all new admission records to identify residents without a Baseline care Plan. No other residents were identified. To ensure this practice does not reoccur the DON/ designee will ensure a baseline care plan is developed for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meets professional standards of care. The DON will ensure the Baseline Care Plan is Developed within 48 hours of a resident's admission and will include at a minimum health care information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social The facility will further provide the resident and/ or their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial problems, goals and interventions for the resident. (ii) A summary of the resident's medications and dietary orders. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This process will be reviewed weekly for next 3 months and reported weekly to the Administrator for the next 3 months and findings will be reported to the QAPI Committee.	

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F 655	Continued From page 5 on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review and interview the facility failed to complete a baseline care plan within 48 hours of admission to the facility for 2 residents (#59 and #67) of 45 residents reviewed. The findings include: Facility policy review, Baseline Care Plan, dated 11/2017, revealed "...The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care...the baseline care plan will be developed within 48 hours of a resident's admission...the admitting nurse, or supervising nurse on duty, shall gather information from the admission physical assessment, hospital transfer information, physician orders, and discussion with the resident and resident representative, if applicable...a supervising nurse shall verify within 48 hours that a baseline care plan has been developed..." Medical record review revealed Resident #59 was admitted to the facility on 4/15/19 with diagnoses which included Cutaneous Abscess of Right Foot, Secondary Gout, and Peripheral Autonomic Neuropathy. Medical record review of Resident #59's baseline care plan revealed the baseline care plan was completed on 4/19/19.	F 655	To ensure ongoing compliance, the DON will track and trend the process for compliance for the next 3 months. The DON will report the results to the Administrator weekly the findings for newly admitted baseline care plans. The DON/designee and the Administrator will review the process and discuss findings with the QAPI committee monthly. The administrator will report to the Governing Body at their next meeting.	6/7/19

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F 655	Continued From page 6 Medical record review revealed Resident #67 was admitted to the facility on 4/15/19 with diagnoses which included COPD (Chronic Obstructive Pulmonary Disease), Pain, Hypertension, Anxiety, and Acute Respiratory Infection. Medical record review revealed there was no baseline care plan for Resident #67. Interview with the Regional Nurse Consultant on 5/21/19 at 7:50 AM in the conference room revealed the admitting nurse was responsible for initiating the baseline care plan. Continued interview confirmed "the baseline care plan on Resident #67 was not done." Interview with the Director of Nursing on 5/21/19 at 8:40 AM in her office revealed baseline care plans were to be completed upon admission and the admitting nurses were responsible for completing the baseline care plan. Continued interview confirmed Resident #59 was admitted on 4/15/19 and the baseline care plan was completed 4/19/19. Continued interview confirmed the baseline care plan for Resident #59 was not completed within 48 hours of admission.	F 655		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to--	F 657	**657 Care Plan Timing and Revision SS=D CFR(s): 483.21(b)(2)(i)-(iii)** **Resident #6 and #72**	

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F 657	Continued From page 7 (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on facilty policy review, medical record review, observation and Interview, the facility failed to revise/update comprehensive care plans for 2 residents (#6 and #72) of 45 resident care plans reviewed. The findings include: Review of Comprehensive Care Plan Policy dated 4/2018 revealed "...It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessments...the	F 657	On 5/21/19, upon being notified of the deficient practice, the DON and Regional Nurse consultant reviewed the Comprehensive Care Plan Policy for any needed revision. No revisions were needed. An interdisciplinary team composed of the attending physician; a licensed nurse responsible for the resident, a nurse aide with responsibility for the resident, the dietician, and the MDS Coordinator met on 5/21/19 to revise and update the care plans for Resident #6 and #72. Resident #6 care plan was revised on 5/21/19 to reflect the resident's current code status. Resident #72 care plan was revised on 5/21/19 to reflect the current plan for a low air loss mattress. The interventions of bolster mattress and ambulation discontinued. The revised and updated care plan now describes the services to be furnished to attain and maintain the residents' highest practical physical, mental and psychosocial well-being. All residents could potentially be affected. Changes and updates to the Care Plan are discussed at the daily QA meeting and revisions are made by the MDS coordinator as needed. A complete care plan audit for accuracy of resident care and needs was initiated on 06/10/2019 by the DON for the MDS Coordinator. Projected audit completion of resident care plans is 06/30/2019. Adverse findings during the audit will be reported to the DON and the care plan will be updated. An in-service on updating Comprehensive Care Plans was conducted by the Administrator with the MDS coordinator on 6/7/19. The care plan procedure will be monitored by the DON or designee weekly three months to ensure the Comprehensive Care Plans are revised and updated timely.	

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F 657	Continued From page 8 comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS [Minimum Data Set] assessments...The comprehensive care plan will describe, at a minimum, the following: The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being..." Medical record review revealed Resident #6 was admitted to the facility on 1/3/19 with diagnoses which included Urinary Tract Infection, Anemia and Malignant Neoplasm of Pancreatic Duct. Medical record review of Resident #6's Physician Orders for Scope of Treatment (POST) form dated 1/3/19 revealed "...DNR (do not attempt resuscitate [perform cardiopulmonary resuscitation if a patient's heart stops beating or the patient stops breathing])..." Medical record review of Resident #6's admission Face Sheet dated 1/3/19 revealed "Do Not Resuscitate." Medical record review of Resident #6's comprehensive care plan dated 1/11/19 revealed the resident's code status was Full Code (meaning to perform cardiopulmonary resuscitation). Medical record review of Resident #6's Physician Order Sheet dated March 2019 revealed "...Do Not Resuscitate (DNR)...admit to hospice..." Medical record review of Resident #6's Significant change MDS dated 3/4/19 revealed the resident received hospice services.	F 657	In order to ensure ongoing compliance, the DON or designee will audit the Facility Comprehensive Care Plan process for the next 3 months. Adverse findings will be reported to the Administrator and the QA committee monthly for 3 months. The administrator will report the monitoring results to the Governing Body at their next meeting.	6/30/19

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F 657	Continued From page 9 Medical record review of Resident #72's care plan dated 4/23/18-Present revealed "...Bolster mattress...Provide reminders to use ambulation and transfer assist devices...STATUS: Active (Current)..." Continued review revealed the resident was on a low air loss mattress and was not reflected on the resident's current care plan. Medical Record Review of the Quarterly MDS assessment dated 5/1/19 revealed "...diagnosis of Cerebrovascular Accident (CVA); stage 4 pressure ulcer; walking in room and corridor, activity did not occur..." Observations on 5/19/19 at 10:19 AM and 12:45 PM on 5/20/19 at 2:15 PM; and on 5/21/19 at 1:50 PM revealed Resident #72 had a low air loss mattress in place. Observation on 5/20/19 at 2:30 PM in Resident #72's room revealed the resident was transferred from the bed to a reclining chair with 2-person assist using a mechanical lift. Interview with MDS Coordinator #1 on 5/21/19 at 9:25 AM in her office revealed MDS staff were responsible for updating resident care plans with quarterly, annual or significant change MDS reviews. Continued interview confirmed when asked to look at Resident #6's care plan and POST form, she stated "the post form states DNR and the care plan states full code, it was just overlooked." Interview with MDS Coordinator #2 on 5/21/19 at 9:30 AM in her office confirmed "her [Resident #6] care plan was not updated to reflect her DNR status; it should have been done with the sig	F 657		

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F 657	Continued From page 10 [significant] change." Interview with the Director of Nursing (DON) on 5/20/19 at 5:30 PM in her office revealed when asked to review Resident #72's care plan she confirmed "the care plan is not specific for low air loss mattress; the Bolster mattress should not be on here, it's an old intervention; ambulation interventions were also out of date." Continued interview confirmed "he [Resident #72] should have been care planned for the low air loss mattress." Interview with the DON on 5/21/19 at 12:59 PM in her office revealed MDS staff were responsible for revising care plans with the MDS assessments. Continued interview when asked to review Resident #6's care plan and POST form confirmed Resident #6's comprehensive care plan was not revised, she stated "they just missed it and didn't do it accurately."	F 657		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized	F 761	**F761 DD=D Label/Store Drugs and Biologicals 483.45 (g)(h)(1)(23)** On 5/21/2019, upon being notified of the deficient practice, the Regional Nurse consultant secured the resident's medication. Nurse #1 was relieved of her responsibility for that medication cart on 5/21/2019 and brought to the Administrator for disciplinary action. The DON educated the nurse on policy for securing and storage of medications appropriately on the med cart on 05/21/2019.	

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	445262	A. BUILDING _____ B. WING _____	05/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND HEALTH CARE AND REHABILITATION INC	4343 ASHLAND CITY HWY NASHVILLE, TN 37218

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F 761	Continued From page 11 personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on facility policy review, observation and interview the facility failed to store medications properly related to medications being left unattended in a medication cup on top of a medication cart. The findings include: Facility policy review, Medication and Biological Storage, Night/Emergency Box and Backup Pharmacy, dated 11/2017 with revision date 4/25/19, revealed "...All medications are stored in designated areas which are sufficient to ensure proper security..." Observation on 5/21/19 at 8:18 AM in the 200 hall in the presence of the support staff administrator revealed the 200 Hall medication cart was unattended with a medication cup with 4 unidentified capsules in the cup sitting on top of the medication cart. Continued observation revealed two residents were sitting in the hallway near the medication cart and staff and visitors walked by the medication cart. Interview with the supportive staff administrator	F 761	All residents in the building could be affected by the deficient practice. On 5/21/19 the Administrator and Director of Nursing reviewed the Policy on Medication storage with no revisions required. On 6/7/19 the nurses were in serviced by the DON on the policy and procedure to secure all medications This included storing all drugs in locked compartments under proper temperature controls and permitting only authorized personnel to have access. To ensure this practice does not reoccur, medication pass will be monitored by DON or designee daily for the next thirty then weekly audited for the next 3 months for compliance. This will be recorded on a medication pass audit form with the cart observed, who did the observation and findings noted. The audit findings will be given to the Administrator and QAPI committee. Each licensed nurse will be instructed on 06/07/2019 by the DON or designee on the Policy of Medication storage. This will be included in the annual competency testing for nursing staff and covered with all-staff annual in-service. In order to ensure ongoing compliance, the medication pass audit form will be reviewed by the Administrator or designee weekly for the next three months for compliance. The DON will report the Monitoring results at the next two quarterly QAPI committee meetings for tracking and trending. The Administrator will report the monitoring results to the Governing Body at the next meeting.	6/7/19

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F 761	Continued From page 12 on 5/21/19 at 8:21 AM in the 200 Hall confirmed medications of 4 unidentified capsules were in a medication cup on top of the unattended 200 Hall medication cart. Continued interview confirmed the nurses were to be in attendance of the medication carts at all times and medications were not to be left on top of the cart unattended.	F 761		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on facility policy review, observation and interview, the facility failed to maintain 1 of 2 ice machines in a clean and sanitary condition to prevent cross contamination of the ice and failed to store foods in safe and sanitary manner to prevent cross contamination.	F 812	**F812 SS=D 483.60(i)(2) Store, prepare, distribute and serve food in accordance with professional standards for food service safety (failed to store foods in a safe and sanitary manner)** On 5/19/2019, upon finding the coke can in the ice, it was immediately removed by kitchen staff. Maintenance was notified of the Coke can and immediately dumped all ice from ice machine on 05/19/2019. The ice machine was cleaned by kitchen staff on 5/19/2019 and then new ice was made. No ice was served to residents during this time frame. All residents in the building could be affected by the deficient practice. On 5/19/19, dietary staff were inserviced by the RD on proper ice storage. A sign was placed on ice machine stating "no food or drink is to be placed in ice bin."	

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F 812	Continued From page 13 The findings include: Facility policy review, Proper Ice Storage, dated August 2014, revealed "...Ice shall be maintained and served in a sanitary manner..." Facility policy review, Food Service, dated 1/2008, revealed "...All dry foods and goods must be stored in a manner to prevent possible contaminations..." Facility policy review, Food Storage, dated 10/2018, revealed "...Scoops for flour, sugar and cornmeal should be stored separately...All stored items should have an expiration date or purchase date/delivery date...All non-food supplies such as soaps, detergents, cleaning compounds or similar substance will be stored in separate areas from food..." Observation of the main ice machine in the kitchen on 5/19/19 at 8:55 AM revealed an unopened drink sitting down in the ice. Observation on 5/19/19 at 9:00 AM revealed 3-32 ounce containers of chemicals stored with the clean water pitchers. Observation on 5/19/19 at 9:15 AM revealed a 10 pound box of Pollock (fish) found opened and undated in the freezer. Observation of the sugar bin in the kitchen on 5/19/19 at 9:25 AM revealed a measuring cup/scoop, no handle, found down in the sugar. Interview with the Dietary Cook on 5/19/19 at 8:58 AM in the kitchen revealed "that's a no no, there should not be anything in the ice."	F 812	Beginning 5/19/19, the kitchen cleaning list was updated by the RD to include "check ice machine for foreign objects" on both AM and PM shifts. Kitchen staff were in-serviced by the RD on 5/19/19 of the update to cleaning list. The RD will audit cleaning list weekly for the 3 months for compliance and report findings to the administrator. The cleaning list will be reviewed by the RD weekly for the next 3 months. Findings will be reported to the administrator and QAPI committee monthly for the next three months. The Administrator will report the findings and corrective action to the Governing Body at their next meeting. **F812 SS=D 483.60(i)(2) Store, prepare, distribute and serve food in accordance with professional standards for food service safety** On 05/20/2019 all deficient practices were immediately addressed by the kitchen staff. Chemicals were immediately placed back in the chemical room. Fish that was found opened and not dated in the freezer was immediately thrown out on 05/20/2019. The scoop that was stored in the sugar was immediately removed on 05/20/2019.	6/7/19

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F 812	Continued From page 14 Interview with the Registered Dietician (RD) on 5/19/19 at 9:40 AM in the kitchen confirmed "no foreign objects should be in the ice." Interview with the Dietary Manager on 5/19/19 at 1:30 PM in the kitchen confirmed "Nothing should be left in the ice; not even a scoop." Interview with the Dietary Aide on 5/19/19 at 9:02 AM in the kitchen revealed "cleaners were not to be stored by clean water pitchers." Interview with the RD on 5/19/19 at 9:40 AM in the kitchen confirmed "Dishware should not be stored with cleaning agents." Interview with the Dietary Cook on 5/19/19 at 9:18 AM in the conference room revealed "opened and undated foods are not to be left in the freezer." Interview with RD on 5/19/19 at 9:44 AM confirmed "opened and undated foods should not be found in the freezer." Interview with the RD on 5/19/19 at 9:42 AM in the kitchen confirmed "scoops/cups were not to be left in the sugar." Interview with the Dietary Manager on 5/19/19 at 1:32 PM confirmed "absolutely nothing should be left in the sugar bin."	F 812	All residents could potentially be affected by the deficient practices. On 06/05/2019 the dietary staff were in-serviced by the RD on chemical storage, dating open foods, and scoop storage. To ensure the deficient practices do not reoccur, the kitchen cleaning list was updated by the RD on 05/20/2019 to include "check that all chemicals are stored in proper area" and "check to ensure there are no foreign objects in ice machine". The cleaning list already includes to check freezer for dates. Kitchen staff was in-serviced by the RD on 05/20/2019 on the updated cleaning list. The RD will check cleaning list weekly for 3 months for compliance. The cleaning log will be signed by RD weekly. Findings will be reported to the administrator and QAPI Committee. The cleaning list will be reviewed by the RD weekly for the next 3 months. The RD will report findings at the next three monthly QAPI meetings. The Administrator will report the findings and corrective actions to the Governing Body at their next meeting.	6/7/19

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E 000	Initial Comments An emergency preparedness survey was completed on 5/19/19 to 5/21/19 at Cumberland Health Care and Rehabilitation Inc. No deficiencies were cited under FED-E-1.00.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Savannah Choate
TITLE: Administrator
(X6) DATE: 6/7/19

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.